		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0043497

Facility Name: Cherrywood Health Care Center

Address: 1500 West St. Louis Avenue (Number) Vandalia (City) 62471 (Zip Code)

County: Fayette

Telephone Number: (618) 283-4262 **Fax #** (618) 283-4313

IDPA ID Number: 830320180009

Date of Initial License for Current Owners: 2/7/1998

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: William H. Keys **Telephone Number:** (317)566-1586

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) William H. Keys
(Title) Chief Financial Officer

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Chris Murphy, CPA, Partner
(Firm Name & Address) BKD, LLP, 6120 S. Yale, Suite 1400
(Telephone) (918) 584-2900 Fax # (918) 584-2931

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Cherrywood Health Care Center # 0043497 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	57	Skilled (SNF)	57	20,862	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	57	TOTALS	57	20,862	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	14,499	3,241	1,854	19,594	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,499	3,241	1,854	19,594	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.92%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A - None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 2/7/1998

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/7/1998 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 57 and days of care provided 1,854

Medicare Intermediary Trailblazer Health Enterprises, L.L.C.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Cherrywood Health Care Center # 0043497 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	94,042	7,574	4,750	106,366		106,366		106,366			1
2	Food Purchase		94,522		94,522		94,522	(1,646)	92,876			2
3	Housekeeping	65,506	7,852		73,358		73,358		73,358			3
4	Laundry	23,288	7,605		30,893		30,893	(220)	30,673			4
5	Heat and Other Utilities			77,094	77,094		77,094	(3,765)	73,329			5
6	Maintenance	24,352	3,926	15,562	43,840		43,840	1,380	45,220			6
7	Other (specify):* Waste Removal			4,753	4,753		4,753		4,753			7
8	**TOTAL General Services**	207,188	121,479	102,159	430,826		430,826	(4,251)	426,575			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	613,966	87,826	150,235	852,027		852,027	4	852,031			10
10a	Therapy		96	85,702	85,798		85,798		85,798			10a
11	Activities	24,598	820	6,154	31,572		31,572		31,572			11
12	Social Services	45,493		2,902	48,395		48,395		48,395			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* Non allow cost											15
16	**TOTAL Health Care and Programs**	684,057	88,742	254,593	1,027,392		1,027,392	4	1,027,396			16
	C. General Administration											
17	Administrative			71,042	71,042		71,042		71,042			17
18	Directors Fees											18
19	Professional Services			27,578	27,578		27,578	15,300	42,878			19
20	Dues, Fees, Subscriptions & Promotions			14,641	14,641		14,641	(4,120)	10,521			20
21	Clerical & General Office Expenses	41,059	7,861	19,567	68,487		68,487	184,165	252,652			21
22	Employee Benefits & Payroll Taxes			169,780	169,780		169,780		169,780			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,740	8,740		8,740	3,145	11,885			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			80,078	80,078		80,078	22	80,100			26
27	Other (specify):*											27
28	**TOTAL General Administration**	41,059	7,861	391,426	440,346		440,346	198,512	638,858			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	932,304	218,082	748,178	1,898,564		1,898,564	194,265	2,092,829			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Cherrywood Health Care Center #0043497 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			65,427	65,427		65,427	419	65,846			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							4	4			32
33	Real Estate Taxes			27,140	27,140		27,140	30	27,170			33
34	Rent-Facility & Grounds							1,650	1,650			34
35	Rent-Equipment & Vehicles			117,606	117,606		117,606	168	117,774			35
36	Other (specify):* See Attached											36
37	**TOTAL Ownership**			210,173	210,173		210,173	2,271	212,444			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			808	808		808		808			38
39	Ancillary Service Centers		61,656	1,724	63,380		63,380		63,380			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			63,684	63,684		63,684		63,684			42
43	Other (specify):* Lab & Rad											43
44	**TOTAL Special Cost Centers**		61,656	66,216	127,872		127,872		127,872			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	932,304	279,738	1,024,567	2,236,609		2,236,609	196,536	2,433,145			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Cherrywood Health Care Center # 0043497 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,403)	02		4
5	Telephone, TV & Radio in Resident Rooms	(3,765)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(243)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,608)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(710)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,280)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Vending Revenue	(1,147)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (15,156)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	211,692	Var	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 211,692		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 196,536		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Cherrywood Health Care Center

ID# 0043497

Report Period Beginning: 1/1/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Other-Attach Schedule - Goodwill	$ 0		1
2	Other-Attach Schedule - Other non allowable exp	0		2
3	Other-Attach Schedule - Vending revenue	(1,147)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,147)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Cherrywood Health Care Center # 0043497 **Report Period Beginning:** 1/1/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,646)	0	0	0	0	0	0	0	0	0	0	(1,646)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	(220)	0	0	0	0	0	0	0	0	0	(220)	4
5	Heat and Other Utilities	(3,765)	0	0	0	0	0	0	0	0	0	0	(3,765)	5
6	Maintenance	0	1,380	0	0	0	0	0	0	0	0	0	1,380	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,411)	1,160	0	0	0	0	0	0	0	0	0	(4,251)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	4	0	0	0	0	0	0	0	0	0	4	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	4	0	0	0	0	0	0	0	0	0	4	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(710)	16,010	0	0	0	0	0	0	0	0	0	15,300	19
20	Fees, Subscriptions & Promotions	(4,280)	160	0	0	0	0	0	0	0	0	0	(4,120)	20
21	Clerical & General Office Expenses	(4,755)	188,920	0	0	0	0	0	0	0	0	0	184,165	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	3,145	0	0	0	0	0	0	0	0	3,145	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	22	0	0	0	0	0	0	0	0	22	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(9,745)	205,090	3,167	0	0	0	0	0	0	0	0	198,512	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(15,156)	206,254	3,167	0	0	0	0	0	0	0	0	194,265	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Cherrywood Health Care Center # 0043497 **Report Period Beginning:** 1/1/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	419	0	0	0	0	0	0	0	0	419	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	4	0	0	0	0	0	0	0	0	4	32
33	Real Estate Taxes	0	0	30	0	0	0	0	0	0	0	0	30	33
34	Rent-Facility & Grounds	0	0	1,650	0	0	0	0	0	0	0	0	1,650	34
35	Rent-Equipment & Vehicles	0	0	168	0	0	0	0	0	0	0	0	168	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	2,271	0	0	0	0	0	0	0	0	2,271	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(15,156)	206,254	5,438	0	0	0	0	0	0	0	0	196,536	45

Facility Name & ID Number Cherrywood Health Care Center # 0043497 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Organizational Structure						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Senior Living Properties, LLC	100.00%	$ 0	$	1
2	V	2	Food Purchase		Senior Living Properties, LLC	100.00%	0		2
3	V	3	Housekeeping		Senior Living Properties, LLC	100.00%	0		3
4	V	4	Laundry		Senior Living Properties, LLC	100.00%	(220)	(220)	4
5	V	5	Heat and Other Utilities		Senior Living Properties, LLC	100.00%	0		5
6	V	6	Maintenance		Senior Living Properties, LLC	100.00%	1,380	1,380	6
7	V	7	Waste Removal		Senior Living Properties, LLC	100.00%	0		7
8	V	10	Nursing & Medical Records		Senior Living Properties, LLC	100.00%	4	4	8
9	V	10a	Therapy		Senior Living Properties, LLC	100.00%	0		9
10	V	17	Administrative		Senior Living Properties, LLC	100.00%	0		10
11	V	19	Professional Services		Senior Living Properties, LLC	100.00%	16,010	16,010	11
12	V	20	Dues, Fees, Subscriptions & Promotions		Senior Living Properties, LLC	100.00%	160	160	12
13	V	21	Clerical & General Office Expenses		Senior Living Properties, LLC	100.00%	188,920	188,920	13
14	Total			$			$ 206,254	$ * 206,254	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Cherrywood Health Care Center # 0043497 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Benefits & Payroll Taxes	$	Senior Living Properties	100.00%	$ 0	$	15
16	V	24	Travel and Seminar		Senior Living Properties	100.00%	3,145	3,145	16
17	V	26	Insurance - Prop Liab Malpractice		Senior Living Properties	100.00%	22	22	17
18	V	30	Depreciation		Senior Living Properties	100.00%	419	419	18
19	V	32	Interest		Senior Living Properties	100.00%	4	4	19
20	V	33	Real Estate Taxes		Senior Living Properties	100.00%	30	30	20
21	V	34	Rent - Facility & Grounds		Senior Living Properties	100.00%	1,650	1,650	21
22	V	35	Rent - Equipment & Vehicles		Senior Living Properties	100.00%	168	168	22
23	V	36	Loss, Goodwill, & Depreciation		Senior Living Properties	100.00%	0		23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 5,438	$ * 5,438	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Cherrywood Health Care Center # 0043497 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Cherrywood Health Care Center # 0043497 Report Period Beginning: 1/1/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Senior Living Properties, LLC
Street Address: 12900 N. Meridian Street, Suite 180
City / State / Zip Code: Carmel, Indiana 46032
Phone Number: (317)566-1586
Fax Number: (317) 581-9513

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	See Attachment	See Attachment	See Attachment	$ 0	$	See Attachment	$ 0	1
2	2	Food Purchase	See Attachment	See Attachment	See Attachment	0		See Attachment	0	2
3	3	Housekeeping	See Attachment	See Attachment	See Attachment	0		See Attachment	0	3
4	4	Laundry	See Attachment	See Attachment	See Attachment	(14,096)		See Attachment	(220)	4
5	5	Heat and Other Utilities	See Attachment	See Attachment	See Attachment	0		See Attachment	0	5
6	6	Maintenance	See Attachment	See Attachment	See Attachment	95,381		See Attachment	1,380	6
7	7	Waste Removal	See Attachment	See Attachment	See Attachment	0		See Attachment	0	7
8	10	Nursing & Medical Records	See Attachment	See Attachment	See Attachment	267		See Attachment	4	8
9	10a	Therapy	See Attachment	See Attachment	See Attachment	0		See Attachment	0	9
10	17	Administrative	See Attachment	See Attachment	See Attachment	0		See Attachment	0	10
11	19	Professional Services	See Attachment	See Attachment	See Attachment	1,026,001		See Attachment	16,010	11
12	20	Dues, Fees, Subscriptions & Prom	See Attachment	See Attachment	See Attachment	10,855		See Attachment	160	12
13	21	Clerical & General Office Expens	See Attachment	See Attachment	See Attachment	12,021,375		See Attachment	188,920	13
14	22	Employee Benefits & Payroll Taxe	See Attachment	See Attachment	See Attachment	0		See Attachment	0	14
15	24	Travel and Seminar	See Attachment	See Attachment	See Attachment	272,954		See Attachment	3,145	15
16	26	Insurance - Prop Liab Malpractic	See Attachment	See Attachment	See Attachment	1,435		See Attachment	22	16
17	30	Depreciation	See Attachment	See Attachment	See Attachment	26,841		See Attachment	419	17
18	32	Interest	See Attachment	See Attachment	See Attachment	249		See Attachment	4	18
19	33	Real Estate Taxes	See Attachment	See Attachment	See Attachment	1,914		See Attachment	30	19
20	34	Rent-Facility & Grounds	See Attachment	See Attachment	See Attachment	105,820		See Attachment	1,650	20
21	35	Rent-Equipment & Vehicles	See Attachment	See Attachment	See Attachment	10,725		See Attachment	168	21
22	36	Loss, Goodwill, & Depreciation	See Attachment	See Attachment	See Attachment	0		See Attachment	0	22
23										23
24										24
25	TOTALS					$ 13,559,723	$		$ 211,692	25

Facility Name & ID Number Cherrywood Health Care Center # 0043497 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Cherrywood Health Care Center # 0043497 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	26,281	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	26,281	2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	27,140	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	27,140	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	21,496	8
	2000	14,334	9
	2001	24,805	10
	2002	26,247	11
	2003	26,478	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Cherrywood Health Care Center COUNTY Fayette

FACILITY IDPH LICENSE NUMBER 0043497

CONTACT PERSON REGARDING THIS REPORT William H. Keys

TELEPHONE (317)566-1586 FAX #: (317)581-9513

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-14-17-453-012	See Attached	$ 26,478.04	$ 26,478.04
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 26,478.04	$ 26,478.04

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

Facility Name & ID Number Cherrywood Health Care Center # 0043497 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,764 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	159,430	1998	$ 51,312	1
2					2
3	TOTALS	159,430		$ 51,312	3

Facility Name & ID Number Cherrywood Health Care Center # 0043497 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	58		1998	1969	$ 1,165,877	$ 38,863	30	$ 38,863	$	$ 268,799	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Service Phone			1998	86	9	10	9		53	9
10	wallpaper & paint			1998	236		5			236	10
11	Prime & paint			1998	350		5			350	11
12	repair telephone			1998	575	58	10	58		634	12
13	install laundry			1998	650	43	15	43		271	13
14	carpet			1998	791		5			791	14
15	floor tile 50%			1998	4,616	231	20	231		1,442	15
16	install tile			1998	5,201	260	20	260		1,582	16
17	Install A/C Unit-Kitchen			1998	1,873	125	15	125		864	17
18	Overbed Lights			1998	6,006	601	10	601		3,804	18
19	Gas Dryer			1998	6,814	681	10	681		4,316	19
20	Floor Tile			1998	2,832	142	20	142		885	20
21	Wall A/C Sleeve			1998	1,691		5			1,691	21
22	Garbage Disposal			1998	760		5			760	22
23	Intall Overbed Lights			1998	7,000	700	10	700		4,258	23
24	awning			1999	2,329	155	15	155		919	24
25	paint & wallpaper dining			1999	810	40	5	40		810	25
26	room alarm system			1999	4,693	469	10	469		2,542	26
27	alarm system			1999	550	55	10	55		298	27
28	alarm system			1999	730	73	10	73		395	28
29	Hand Rails in Hallway			1999	282	19	15	19		102	29
30	rife panel			2000	2,179	311	7	311		1,323	30
31	replace file panel			2000	2,080	297	7	297		1,288	31
32	electric			2000	2,193	313	7	313		1,723	32
33	Fire Alarmpanel replacement			2004	2,917	97	10	97		97	33
34	Intstall Fresh Air Duct in Laundry Room			2004	1,900	24	20	24		24	34
35	WanderGaurd System			2004	27,642	230	10	230		230	35
36	4 Unit Motion Detector for entrance			2003	800	80	10	80		153	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Cherrywood Health Care Center # 0043497 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Air compressor for fire alarm sprinkler	2001	$ 2,339	$ 156	15	$ 156	$	$ 572	37
38	Air conditioners	2002	7,269	727	10	727		2,120	38
39	Land Improvements	1998	21,412	1,427	15	1,427		9,873	39
40	Blacktop	1998	6,229	779	8	779		4,802	40
41	signage	1998	464	46	10	46		305	41
42	Fence	1999	1,350	90	15	90		473	42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,293,526	$ 47,101		$ 47,101	$	$ 318,785	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Cherrywood Health Care Center # 0043497 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 151,168	$ 17,616	$ 17,616	$	Various	$ 113,655	71
72	Current Year Purchases	17,151	710	710		Various	710	72
73	Fully Depreciated Assets					Various		73
74								74
75	TOTALS	$ 168,319	$ 18,326	$ 18,326	$		$ 114,365	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,513,157	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 65,427	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 65,427	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 433,150	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Cherrywood Health Care Center # 0043497 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 117,607 Description: Nursing - 825, Central Supply - 116,002, Dietary - 539, Administrative - 241
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Cherrywood Health Care Center # 0043497 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a,3	hrs	$	292	$ 9,602	$ 96	292	$ 9,698	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		47	1,538	0	47	1,538	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		2,244	73,770	0	2,244	73,770	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	2,583	$ 84,910	$ 96	2,583	$ 85,006	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Cherrywood Health Care Center # 0043497 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 8,262	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	538,741		3
4	Supply Inventory (priced at)	7,694		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 554,697	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	51,312		13
14	Buildings, at Historical Cost	1,264,070		14
15	Leasehold Improvements, at Historical Cost	29,455		15
16	Equipment, at Historical Cost	168,320		16
17	Accumulated Depreciation (book methods)	(433,150)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp Intercompany			22
23	Other(specify): Intercompany (Pay)/Rec	(3,390,532)		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ (2,310,525)	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ (1,755,828)	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 59,012	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	22,689		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	36,932		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	27,140		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 145,773	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 145,773	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,901,601)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (1,755,828)	$	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,023,900)	1
2	Restatements (describe):		2
3	Accounting Adjustments	167,197	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,856,703)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(44,898)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (44,898)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,901,601)	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,145,023	1
2	Discounts and Allowances for all Levels	(1,604,361)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,540,662	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	146,512	6
7	Oxygen	29,957	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 176,469	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	575	13
14	Non-Patient Meals	1,403	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	120,461	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	28,114	19
20	Radiology and X-Ray	661	20
21	Other Medical Services	322,219	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 473,433	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation		28
28a	Vending	1,147	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,147	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,191,711	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	430,826	31
32	Health Care	1,027,392	32
33	General Administration	440,346	33
	B. Capital Expense		
34	Ownership	210,173	34
	C. Ancillary Expense		
35	Special Cost Centers	64,188	35
36	Provider Participation Fee	63,684	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,236,609	40
41	**Income before Income Taxes (line 30 minus line 40)****	(44,898)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (44,898)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	0	0	$ 0	$	1
2	Assistant Director of Nursing	30	30	565	18.83	2
3	Registered Nurses	3,292	3,570	60,290	16.89	3
4	Licensed Practical Nurses	14,086	15,354	246,402	16.05	4
5	Nurse Aides & Orderlies	32,785	34,867	288,658	8.28	5
6	Nurse Aide Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	1,911	2,082	22,689	10.90	9
10	Activity Assistants	234	236	1,909	8.09	10
11	Social Service Workers	3,769	3,972	45,493	11.45	11
12	Dietician	2,058	2,177	30,041	13.80	12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	8,753	9,172	64,001	6.98	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	1,779	1,928	24,352	12.63	17
18	Housekeepers	7,395	8,204	65,506	7.98	18
19	Laundry	3,146	3,309	23,288	7.04	19
20	Administrator	0	0	0		20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	0	0	0		22
23	Office Manager	0	0	0		23
24	Clerical	2,700	3,048	41,059	13.47	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	1,758	2,047	18,051	8.82	31
32	Other Health Care(specify)	0	0	0		32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	83,696	89,996	$ 932,304 *	$ 10.36	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	105	$ 4,750	1, 3	35
36	Medical Director	48	9,600	9, 3	36
37	Medical Records Consultant			10, 3	37
38	Nurse Consultant	0		10, 3	38
39	Pharmacist Consultant	144	1,862	10, 3	39
40	Physical Therapy Consultant			10a, 3	40
41	Occupational Therapy Consultant			10a, 3	41
42	Respiratory Therapy Consultant			10a, 3	42
43	Speech Therapy Consultant			10a, 3	43
44	Activity Consultant	48	6,154	11, 3	44
45	Social Service Consultant	48	2,902	12, 3	45
46	Other(specify) Administrative Consu	2,080	71,042	17,3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,473	$ 96,310		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,080	$ 68,225	10,3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	2,080	$ 68,225		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
Contract Services: Administrator	$ 71,042
Misc. Fees	0
TOTAL (agree to Schedule V, line 17, col. 3)	$ 71,042
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal Fees	Various	$ 710
Patient Litigation	Various	0
Payroll Processing	Various	2,632
Accounting	Various	7,125
EDP Services	Various	17,111
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 27,578

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 55,082
Unemployment Compensation Insurance	0
FICA Taxes	112,175
Employee Health Insurance	(8)
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	2,531
TOTAL (agree to Schedule V, line 22, col.8)	$ 169,780

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	5,250
Health Care Worker Background Check	149
(Indicate # of checks performed 9)	
Dues & Subscriptions	4,802
Advertising & Public Relations	4,280
Home Office Allocation	160
Less: Public Relations Expense	( )
Non-allowable advertising	(4,120)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,521

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	5,205
Seminar Expense	3,478
Business Meals	57
Home Office Allocation	3,145
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,885

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Cherrywood Health Care Center # 0043497 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Cherrywood Health Care Center # 0043497 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **0 N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **10,597** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility. IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **63,684**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,403**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees